

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 98-1

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Baltimore
 City or town Belt-312
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

County home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Harford
 City or town Belt
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Carrie Anderson

3. (b) Social Security Number

4. Sex

fe-male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

X

6.(b) Name of husband or wife

John Anderson

7. Birth date of

deceased (mo., day, yr.)

Jan. 16. 1863.

6.(c) If alive, give age _____ years

8. AGE:

Years

82

Months

9

Days

29

If less than one day

_____ hrs. _____ min.

9. Birthplace

Washington D.C.

(City, county, and state)

10. Usual occupation

Retiree

11. Industry or business

FATHER

12. Name

Frederick G. Gable

13. Birthplace

Washington D.C.

14. Maiden name

W. Gable

15. Birthplace

Washington

18. Informant

Clark J. Gable

Address

Belt 312

17.

(Burial, cremation, or removal. Whole or part)

Date thereof

Mar 15/45
(month) (day) (year)

Cemetery or crematory

St. John's

Location

Trinity Green

18. Funeral director

Dean & Sons

Address

Belt 312

19.

(Date rec'd by registrar)

11-14 45

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 19 45 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 10, 19 45, to Nov. 14 19 45and that I last saw her alive on Nov. 13, 19 45

Immediate cause of death

arteriosclerotic heart disease

DURATION

5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

Signature

Edward F. Anderson
For 312 M. D. or other _____ Date signed 11/14/45

RECEIVED

NOV 20 1945

BUREAU V.S.

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County HarfordCity or town Harford de Grace
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 55 minutes

Hospital, institution, or street address where death occurred:

Harford Memorial Hosp.How long in hospital or institution? 55 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Charles B Bare

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife _____

B. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 21, 19458. AGE: Years Months Days If less than one day
2 15 _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Infant

11. Industry or business _____

12. Name Alvis Bare13. Birthplace North Carolina14. Maiden name Mamie Brinegar15. Birthplace North Carolina16. Informant Mamie BareAddress Aberdeen, Md.17. Burial Date thereof 11/7/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Angel HillLocation Harford de Grace, Md.18. Funeral director Remington & SonAddress Harford de Grace, Md.19. Nov. 7th 19 45 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5th 19 45 at 6:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death

Acidosis

DURATION

2 daysDue to DehydrationDue to Malnutrition, e.s.o.Other conditions Child died on arrival at hospital. No adequate history on physical examination was possible.
(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Gerald C Palmer M.D.23. SIGNATURE Deputy Medical ExaminerHarford County M. D. or otherAddress Bel Air, Md. Date signed 11/6/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11114

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NOV 8 1945

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

11115

Reg. Dist. No. 125

1. PLACE OF DEATH:

County HarfordCity or town House de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Camilla St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town House de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. Camilla Street
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Annie Eliza Bowden

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Hobrey Bowden6. (c) If alive, give age 76 years7. Birth date of deceased (mo., day, yr.) September 21, 18748. AGE: Years 71 Months 2 Days 7 If less than one day
hrs. min.8. Birthplace Maryland
(Town, county, and state)10. Usual occupation House duties

11. Industry or business

12. Name Carroll H. Maslin13. Birthplace md.14. Maiden name Alice Allen15. Birthplace md.16. Informant Merrell R. BowdenAddress Camilla Street17. Burial Date thereof Dec. 21, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Angel HillLocation House de Grace, Md.18. Funeral director R. Madison MitchellAddress 123 So. Wash. St. House de Grace, Md.19. Nov. 28 19 45 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1945 at 7:50 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1, 1945 to Nov. 28, 1945and that I last saw him alive on Nov. 27, 1945Immediate cause of death hypostatic congestion DURATION 2 daysDue to toxemia 4 daysDue to cerebral hemorrhage 6 daysOther conditions Thromboplegia 10 yearsArteriosclerosischronic interstitial nephritis
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. Wallace M.D. M. D. or otherAddress House de Grace Date signed Nov 28

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DEC 1 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

11116

Reg. Dist. No. 180

1. PLACE OF DEATH:

County Hartford
 City or town Edgewood
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Hartford
 City or town Edgewood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Welloughly Beach Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William Rutter Cohee

3. (b) Social Security Number

715-03-3263

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 8.(b) Name of husband or wife Agnes Mary Cohee
 7. Birth date of deceased (mo., day, yr.) Jan. 29, 1884 6.(c) If alive, give age 61 years
 8. AGE: Years 61 Months 9 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Fredricktown, Calver Co., Md
 (Town, county, and state)

10. Usual occupation Fisherman

11. Industry or business

12. Name Stephen Andrew Cohee

13. Birthplace Fredricktown Calver Co. Md

14. Maiden name Agnes Meekins

15. Birthplace Chesapeake City, Md

16. Informant Mrs. Agnes M. Cohee

Address Edgewood, Md

17. Burial Date thereof Nov 12, 1945
 (Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Bethel

Location Chesapeake City, Maryland

18. Funeral director Howard K. McCombs & Son

Address Chingdon, Maryland

19. Nov 12 19 45 Marie M. MacLachlan
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 19 45 at 5:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 19 45, to 11-9 19 45, and that I last saw him alive on Nov 8 19 45.

Immediate cause of death Cerebral hemorrhage DURATION 3 weeks

Due to essential hypertension 10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Med O Hodous, M.D. M.D. or other

Address Edgewood, Md Date signed 11-9-45

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NOV 15 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THIS COUPON IS LIMITED TO

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1576

CERTIFICATE OF DEATH

11117

★ Reg. Dist. No. 186

1. PLACE OF DEATH:

County HarfordCity or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. 330 S. Union Ave.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Stephane Yvonne
Not named Baby Girl Cravens

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Nov. 13, 1945

8. AGE:

Years

Months

Days

'If less than one day

1 hrs. 40 min.9. Birthplace Havre de Grace, Harford Co., Md.
(Town, county, and state)10. Usual occupation Infant

11. Industry or business

FATHER

12. Name Robert Lee Cravens13. Birthplace Linton, Indiana

MOTHER

14. Maiden name Doretha Ames15. Birthplace Obolong, Illinois18. Informant Robert Lee Cravens-FatherAddress 330 S. Union Ave. - Havre de Grace, Md.17. Burial Date thereof Nov. 14, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Angel HillLocation Havre de Grace, Md.18. Funeral director R. Modison MitchellAddress Havre de Grace, Md.19. Nov. 14 1945 G. P. Lavin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1945 at 5:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 13 1945 to Nov. 13 1945

and that I last saw him alive on 19

Immediate cause of death

DURATION

Due to AbnormalDue to Spina BifidaOther conditions Cardiac Failure

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D.Address John W. Dean M.D.Date signed 11/14/45

HEALTH DEPARTMENT OF HEALTH

HEALTH DEPARTMENT OF HEALTH

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NOV 16 1945

BUREAU V S



Bel. Co. 818712

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462 X

CERTIFICATE OF DEATH

11119 185-

Reg. Dist. No. 3632

1. PLACE OF DEATH:

County Harford Memorial Hospital
 City or town Haver Lee Green
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Harford Memorial Hospital

How long in hospital or institution?

8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HarfordCity or town Aberdeen, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 33 Swan St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Teresa Denbow

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Samuel Denbow

7. Birth date of deceased (mo., day, yr.)

Oct. 22, 18908. (c) If alive, give age 55 years

8. AGE:

Years

Months

Days

If less than one day

75 yr.12

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

FATHER
MOTHER

12. Name

Andrew Denbow Drake

13. Birthplace

Md

14. Maiden name

Sam Lockert

15. Birthplace

Md

16. Informant

Mr. Russell Denbow

Address

33 Swan St. Aberdeen

17.

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 7, 1945
(month) (day) (year)

Cemetery or crematory

Chattahoochee Memorial

Location

Capetown, Harford Co.

18. Funeral director

Henry Tawling & Sons

Address

Aberdeen, Md.

19.

(Date rec'd by registrar)

19 45A. L. Lewis M. D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3/45 1945 at 9:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10/30/4519 45to 11/319 45and that I last saw him alive on 11/3 19 45

Immediate cause of death

Carcinoma of sigmoid

Due to

Intestinal

Due to

Obstruction

Other conditions

Toxemia

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Charles J. Foley M.D.

M. D. or other

Address Harford Co. Md. Date signed 11/6/45

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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NOV 8 1945

BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

CERTIFICATE OF DEATH

11120

Reg. Dist. No. 183

1. PLACE OF DEATH:

County Harford
 City or town Janettsville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Harford
 City or town Janettsville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

James Hyter Durman

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Sarah Margaret Fox6.(c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) June 30 1874

8. AGE: Years 71 Months 4 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Seven mile Ford Smith Co Va.
(Town, county, and state)
Farmer

10. Usual occupation _____

11. Industry or business _____

12. Name Charles Durman13. Birthplace Va.14. Maiden name Catherine Copenhagen15. Birthplace Va.16. Informant Mr Sarah DurmanAddress Forest Hill Md.17. Burial Date thereof Dec 2 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt ZionLocation Fountain Green Md.18. Funeral director Martin E. KurtzAddress Janettsville, Md.19. Dec 2 1945 Kilham Brown

(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29- 1945, at 4:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-25- 1945, to 11-29- 1945and that I last saw h.f.m. alive on 11-29-45 - 1945Immediate cause of death Cerebralhemorrhage DURATION 1 wk.Due to Hypertensive cerebro-vascular disease 10 yrs.Due to HypertensionOther conditions none

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22-VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles A. Huff M. D. or other _____Address Janettsville, Md. Date signed 11-30-45

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DEC 11 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MICHIGAN CORPORATE LIMITED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 307

CERTIFICATE OF DEATH

Reg. Dist. No. 1112485-

1. PLACE OF DEATH:

County Harford
 City or town Havre de Grace, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 hrs. 45 min.
 Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
 How long in hospital or institution? 2 hrs. and 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Aberdeen
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 15 Monroo St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Diane Fields

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) November 17, 1945 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
9 hrs. min.

9. Birthplace Aberdeen, Maryland
 (Town, county, and state)
Infant

10. Usual occupation

11. Industry or business

12. Name Leon Fields13. Birthplace Maryland14. Maiden name Margaret Black15. Birthplace Maryland

16. Informant Margaret Fields-Mother
 Address 15 Monroe St.-Aberdeen, Md.

17. Burial Date thereof Nov 29, 45
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. James A.M.E.
Havre de Grace, Md.
 Location

18. Funeral director Elmer E. Billak
 Address 556 Lewis St. Havre de Grace

19. Nov-29 19 45 A. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH November 26 19 45 at 8:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 17 19 45 to Nov 26 19 45
 and that I last saw him alive on Nov 26 19 45

Immediate cause of death

DURATION

PrematurityDue to Septicemia in father

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Elmer E. Billak

M. D. or other

Address Havre de Grace Date signed Nov 28, 45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
DEC 1 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11122 184182

1. PLACE OF DEATH:

County Harford
City or town Whiteford Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford
City or town Whiteford Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Harry Fry

3. (b) Social Security Number

197-10-1346

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mary Fry

6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Jan. 28-1889

8. AGE: Years 56 Months 9 Days 29 hrs. _____ min. _____

9. Birthplace McClellan Ferry, York Co. Pa.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business Filling Station Operator

12. Name Milton Fry

13. Birthplace Lancaster Co. Pa.

14. Maiden name Jessette Kilgore

15. Birthplace York Co. Pa.

16. Informant Mrs. Mary Fry

Address Whiteford, Md.

17. Buried Date thereof Nov 29, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pine Grove cemetery

Location Seamansburg Pa.

18. Funeral director Robert P. Mackinn

Address Delta Pa.

19. Oct. 18, 45 Carl E. Knott
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 45 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 45 to November 27, 45
and that I last saw him alive on November 27, 45

Immediate cause of death Internal bleeding DURATION _____

Due to Melanoma sarcoma of the liver

Due to generalized metastases

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Benzon Stone, MD. M. D. or other _____

Address Cor. Cliff (Md.) Date signed 11-27-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 9 1946
BUREAU V.E.

RECEIVED
JAN 9 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *137A*

CERTIFICATE OF DEATH

11123

★ Reg. Dist. No. *185*

1. PLACE OF DEATH:

County *Harford*
 City or town *Harrods Creek Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *76 yrs.*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State *Maryland* County *Harford*
 City or town *Harrods Creek*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *675-Keen*
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Robert Walter Deunleaf

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Hughes Deunleaf

7. Birth date of deceased (mo., day, yr.)

June 22 - 1869

8. AGE:

Years Months Days If less than one day
76 4 20 - hrs. - min.

9. Birthplace

Harrods Creek (Town, county, and state)

10. Usual occupation

Coal dealer

11. Industry or business

Coal

FATHER

12. Name William Deunleaf

13. Birthplace Sweden

14. Maiden name Catherine G. Deunleaf

15. Birthplace Pennsylvania

16. Informant Mary H. Deunleaf (wife)

Address 675-Keen St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/13/45 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Harrods Creek

18. Funeral director Pennington & Son

Address Harrods Creek

19. Mr. 12 1945-62. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1945 at 7A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 2 1945 to Nov 11 1945

and that I last saw him alive on Nov 11 1945

Immediate cause of death

Chronic Coronary Arteriosclerosis

Due to

Chronic Hypertension

Due to

Tapeemia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles Foley M.D.

Address Harrods Creek Md. Date signed 11/13/45

CERTIFICATE OF DEATH

RECEIVED
NOV 14 1945
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

11124

Reg. Dist. No. 182

1. PLACE OF DEATH: Hartford
 County.....
 City or town..... Belt Air, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Md County..... Hartford
 City or town..... Belt Air, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(c) If veteran, name war.....

3. (a) FULL NAME Anna & Jacob

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife..... Albert M Jacob
 7. Birth date of deceased (mo., day, yr.) Feb 26 / 1906 6. (c) If alive, give age..... years
 8. AGE: Years 39 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace Pa
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

FATHER 12. Name Benj M Dehner

13. Birthplace Pa

MOTHER 14. Maiden name Catharina A Sandrock

15. Birthplace Pa

16. Informant Albert C Jacob

Address Belt Air, Md

17. Buried Date thereof Nov 28 / 45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dehner

Location Stobletex Pa

18. Funeral director Dean Foster

Address Belt Air Md

19. 11-26 1945 Piscilla Forward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 25 1945 at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov 25 1945 to..... 19.....
 and that I last saw h..... alive on Nov 25 19.....

Immediate cause of death..... Cerebral thrombosis

DURATION 12 hrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Gerald C Palmer MD

Address Belt Air Md M. D. or other

Date signed 11/26/45

RECEIVED
NOV 27 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11125 185-
Reg. Diat. No.

1. PLACE OF DEATH:

County Harford
City or town Danville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State N. Carolina County MaconCity or town Charlotte
(If outside city or town limits, write RURAL and give nearest town)Street No. 217 Victoria Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

J. Harry Jones

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Walter Ward Jones
NELLE7. Birth date of deceased (mo., day, yr.) January 22, 18928. AGE: Years 53 Months 9 Days 23 If less than one day9. Birthplace South Carolina
(Town, county, and state)10. Usual occupation Auditor

11. Industry or business

12. Name Walter Ward JONES13. Birthplace South Carolina14. Maiden name Margaret LeMay Annie Eagle15. Birthplace South Carolina16. Informant Douglas H. & RingAddress Charlotte N. C. 1335 Elizabeth Ave.17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Nov. 18-45
(month) (day) (year)Cemetery or crematory Clayton Cem.Location Harford N. Carolina18. Funeral director Douglas H. & RingAddress Charlotte N. Carolina

19. Nov. 16 1945 G. L. Lewis M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1945 at 12:45 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12, 1945 to Nov 14, 1945and that I last saw him alive Nov 14, 1945Immediate cause of death Coronary ThrombosisDue to Coronary Thrombosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D.Address Harford N. Carolina Date signed 11/14/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 17 1945

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MICHIGAN CORPORATION LIMITED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11126

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford
 City or town Harlee de Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
 City or town Chesapeake
 (If outside city or town limits, write RURAL and give nearest town)

Street No. C. C. Bowman
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Henry W. Kennedy

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mary Adeline Kennedy

7. Birth date of

deceased (mo., day, yr.)

11-5-61

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

84-14hrs.min.

9. Birthplace

Harford Co. Maryland
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Patrick Kennedy

13. Birthplace

Ireland

14. Maiden name

Anna Farrell

15. Birthplace

Ireland

16. Informant

Address

Hospital Records
Harlee de Grace Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov 23 - 1945
(month) (day) (year)

Cemetery or crematory

Long Green Cem

Location

Baltimore Co. Md.

18. Funeral director

Address

Kuntzburger & Grass
Benson, Md.

19.

(Date rec'd by registrar)

19

45

G. L. Lewis Jr.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 19 - 1945 at 7:40 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov - 15 - 1945 to Nov 19 - 1945
and that I last saw him alive on Nov - 19 - 1945

Immediate cause of death

Arteriosclerosis
Chronic myocarditis

DURATION

10 yrs
4

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. L. Lewis Jr.
M. D. or other

Address

Post Office Box

Date signed

11/20/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

DEATH CERTIFICATE

DATE OF DEATH

RECEIVED

NOV 24 1945

BUREAU V. L.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472 *

CERTIFICATE OF DEATH

11127

Reg. Dist. No. 181

1. PLACE OF DEATH:

County HarfordCity or town Chesden
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Chesden
(If outside city or town limits, write RURAL and give nearest town)Street No. 117 A Rogers St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Clarence W. Martin

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

8.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 7, 1864

8. AGE:

Years

Months

Days

If less than one day

776

hrs.

min.

9. Birthplace

Harford Co. Md.
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Retired

12. Name

Rev. Louis E. Martin

13. Birthplace

Chesden Md

14. Maiden name

Susie Cole

15. Birthplace

Chesden Md.

18. Informant

Miss. Mary MartinAddress 845 Arlington Village Arlington Va

17.

Burial
(Burial, cremation, or removal, Which?)

Date thereof

Nov 29, 1945
(month) (day) (year)

Cemetery or crematory

Speculation

Location

Perryman Md.

18. Funeral director

Betty Jarvis Jones

Address

Chesden Md.

19.

Nov. 29
(Date rec'd by registrar)

19

45Nellie H. Wiley

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov. 26 1945 at 9:25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July1945, toNov 261945and that I last saw him alive on Nov 26 1945

Immediate cause of death

Barium of lung (tubercle)
Pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public places (whenever?)

Means of injury

Injured at work?

23. SIGNATURE

Thos. P. Thomsen

M. D. or other

Address

Aberdeen MdDate signed Nov 28/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

DEC 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

11128/85-
Reg. Dist. No.

1. PLACE OF DEATH:
County Harford
City or town Harford Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Perryman
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Ethel McFadden

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife James F. McFadden
7. Birth date of deceased (mo., day, yr.) Nov. 12, 1885 8. (c) If alive, give age _____ years

8. AGE: Years 60 Months 59 Days 11 If less than one day _____ hrs. _____ min.

8. Birthplace Delaware
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Chas. H. Fleming

13. Birthplace Delaware

14. Maiden name Ella Jackson

15. Birthplace Maryland

16. Informant Mr. James F. McFadden

Address Cheriden R.F.D.

17. Burial Date thereof Nov. 11, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cheriden

Location Perryman Rd.

18. Funeral director Henry T. Young

Address Cheriden Md.

19. Nov. 10 19 45 H. L. Harris M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th 19 45 at 11:55 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 8 19 45 to Nov 8 19 45 and that I last saw him alive on Nov 8 19 45

Immediate cause of death Intermittent Hemorrhage DURATION 2 hrs

Due to Mesenteric thrombosis 2 hrs

Due to arterio-sclerotic C.V. Disease 2

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results Mesenteric thrombosis Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. R. Rappley M.D. or other _____

Address Cheriden Md. Date signed Nov 9

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
NOV 12 1945
BUREAU V.E.

RECEIVED

DEC 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

11130 180
Reg. Dist. No.

1. PLACE OF DEATH:

County Harford
 City or town Emmorton Edgewood R.D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Emmorton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Edgewood R.D.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

George B. Norris

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Theresa M. Norris

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1860

8. AGE: Years 85 Months 1 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Harford Co. Maryland
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business _____

12. Name John Norris

13. Birthplace Maryland

14. Maiden name Sophia E. McGinnis

15. Birthplace Maryland

16. Informant Theresa M. Norris

Address Emmorton, Edgewood R.D. Md

17. Burial Date thereof Nov. 17 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Emmorton Maryland

18. Funeral director Howard K. McGinnis

Address Abingdon Maryland

Nov. 17 19 45 Marie M. Mouladele

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 19 45 at 9:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10 19 45 to Nov. 13 19 45

and that I last saw him alive on November 13 19 45

Immediate cause of death Coronary Heart failure DURATION 4 days

Due to arteriosclerotic Heart Disease 3 yrs

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Abd L. Hudson MD

Address York Md Date signed 11/13/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF VITALS

NAME OF DECEASED

DATE OF DEATH

PLACE OF BIRTH

RECEIVED
NOV 21 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

11131

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford
 City or town Rural Del. Cir.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 85 yrs 11 mos
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Rural Del. Cir. 17-85
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Harford Furnace
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

James Oliver

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary M. Stumpster

7. Birth date of deceased (mo., day, yr.) Nov. 29 - 1859 6. (c) If alive, give age 85 years

8. AGE: Years 85 Months 11 Days If less than one day hrs. min.

9. Birthplace Harford Co. Md.
 (Town, county, and state)

10. Usual occupation Farmer11. Industry or business RetiredFATHER 12. Name William Oliver13. Birthplace IrelandMOTHER 14. Maiden name Sarah McCay15. Birthplace Ireland16. Informant Mrs. Edward C. OliverAddress 2827 Chesland Ave Baltimore Md

17. Burial Date thereof Nov 19, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. MarysLocation Emmerton Harford Co Md18. Funeral director Henry Towing SonsAddress Chesland Md

19. Nov. 19 19 45 Nellie Riley
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 19 45 at 11:33 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 6 19 45 to Nov 17 19 45

and that I last saw him alive on Nov 16 19 45

Immediate cause of death auricular fibrillation
cardiac decompensation

Due to arteriosclerosisDue to Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Thos. P. Thompson M.D.Address Arden Md Date signed Nov 19/45

RECEIVED

DEC 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

CERTIFICATE OF DEATH

11132

Reg. Dist. No. 184

1. PLACE OF DEATH:
 County Harford
 City or town Darlington-Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 mo.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Darlington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Isabel Knapp Sawmill Camp
near Darlington
 2(a) If veteran, name war MS

3. (a) FULL NAME James Ralph Richardson

3. (b) Social Security Number MS

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Wm

7. Birth date of deceased (mo., day, yr.) Nov 29 1944 6. (c) If alive, give age _____ years

8. AGE: Years 11 Months 17 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Harford Co., Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business MS

12. Name James Richardson

13. Birthplace Har Co. N.C.

14. Maiden name Waver Faircloth

15. Birthplace Grayson, Va.

16. Informant Waver Faircloth

Address Darlington Md.

17. Burial Date thereof Nov. 17 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Public Cem.

Location Harford Co. Md.

18. Funeral director H. D. Bailey

Address Darlington Md.

19. Nov. 16 45 M. D. Clark
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1945 at 2:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Burned to death

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of Nov 15 1945

Where did injury occur? Darlington Harford Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Burned in home fire Injured at work?

23. SIGNATURE Jonah A. Hunt M.D.
Asst. Reg. Med. Examin. M. D. or other

Address Crofton Md. Date signed Nov. 15, 1945

RECEIVED

DEC 4 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Diat. No. 11133 183

1. PLACE OF DEATH:

County HarfordCity or town Bel Air

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Thomas Henderson Shelton

3. (b) Social Security Number

220-22-00804. Sex male5. Color or race white6. (a) Single, married, widowed, or divorced widower6. (b) Name of husband or wife Dolie Kithman Shelton7. Birth date of deceased (mo., day, yr.) Sept 13 1878

6. (c) If alive, give age _____ years

8. AGE: Years 67 Months 1 Days 27 If less than one day _____ hrs. _____ min.9. Birthplace Flugh Co. Va.

(Town, county, and estate)

10. Usual occupation Farmer11. Industry or business Retired12. Name George Peter Shelton13. Birthplace Va.14. Maiden name Laura E. Howard15. Birthplace Va.16. Informant Miss Laura E. SheltonAddress Bel Air Md.17. Burial Date thereof Nov. 12 - 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory JanettsvilleLocation Janettsville, Harford Co. Md.18. Funeral director Marion E. KutzAddress Janettsville Md.19. 11. 10 45 Priscilla Louwood

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1945 at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death coronary occlusion

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Gerald C. Palmer M.D.Deputy Medical Examiner

M. D. or other _____

Address Bel Air Md. Date signed 11/10/45

RECEIVED
NOV 12 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 11134 182

1. PLACE OF DEATH:

County.....Harford
 City or town.....Rural Bel Air
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....4 mo.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Harford
 City or town.....Rural Bel Air Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....Brimwood Harford Co. Md
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....None

3. (a) FULL NAME

Mrs. Mary Jane Smothers

3. (b) Social Security Number

None

4. Sex.....Female 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Married
 6.(b) Name of husband or wife.....Wm Mc. Smothers
 6.(c) If alive, give age.....61 years
 7. Birth date of deceased (mo., day, yr.).....March 14-1883
 8. AGE: Years.....62 Months.....8 Days..... If less than one day..... hrs. min.

9. Birthplace.....Smith Co. Va
 (Town, county, and state)

10. Usual occupation.....Housewife

11. Industry or business

12. Name.....Nancy Tilks

13. Birthplace.....Smith Co. Va

14. Maiden name.....Melinda Burnes

15. Birthplace.....Smith Co. Va

16. Informant.....Mrs. Wm Mc. Smothers

Address.....Bel Air Md. R.F.D. #2

17. Burial Date thereof.....Nov. 5-1945
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory.....Smith Chapel

Location.....Churchville Harford Co. Md

18. Funeral director.....Nancy Taming Mrs

Address.....Chesapeake Md.

19. 11-4 45 Priscilla Brown
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Nov. 2 1945 at 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....19..... to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

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DURATION

Major findings of operations.....

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RECEIVED
NOV 6 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(942)

CERTIFICATE OF DEATH

11135/82

Reg. Dist. No.

1. PLACE OF DEATH: Hartford
 County.....
 City or town..... Bell Air, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 23 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Md County..... Hartford
 City or town..... Bell Air, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME J Leslie Steen

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife..... Lida B Steen

7. Birth date of deceased (mo., day, yr.) Aug 7 - 1881 5.(c) If alive, give age..... years

8. AGE: Years 64 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... N. D.
 (Town, county, and state)

10. Usual occupation..... Clrk

11. Industry or business.....

12. Name..... J Leslie Steen

13. Birthplace..... Pa

14. Maiden name..... Elizabeth Steen

15. Birthplace..... Md

16. Informant..... Wm Bradford

Address..... Bell Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof..... Dec 1 / 45
 (month) (day) (year)

Cemetery or crematory..... Rock Spring

Location..... Bell Air, Md

18. Funeral director..... Dean & Foster

Address..... Bell Air Md

19. 11-30 45 Priscilla Fourwood
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 29 1945 at 12³⁰ A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29 - 1945 to Nov. 29 - 1945

and that I last saw him..... Nov. 29 - 1945

Immediate cause of death..... Angina Pectoris

DURATION

1/2 hour

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... A. F. Van Fosse

M. D. or other

Address..... Bell Air, Md

Date..... Nov. 29, 1945

RECEIVED

DEC 4 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74-2

CERTIFICATE OF DEATH

Reg. Dist. No. 11136 182

1. PLACE OF DEATH:

County *Harford*City or town *Bel Air*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Harford*City or town *Bel Air*
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George Washington SUTTON

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

8.(b) Name of husband or wife

Mary Leannington

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *11/20/45*
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. *11-19*

(Date rec'd by registrar)

*45**Priscilla Howard*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

*11/18*19 *45* at *4:30* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 10 19 *45* to *Nov 18* 19 *45*and that I last saw him alive on *Nov 17* 19 *45*

Immediate cause of death

Cerebral Hemorrhage

DURATION

6 days

Due to

Hypertension - Coronary disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

M. Hopkins

M. D. or other

Address *Bel Air Md* Date signed *11/19/45*

RECEIVED

NOV 23 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of
age is shown on
G 99 12-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11137

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford
City or town Bural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Harford
City or town Bural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. None
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

Rev. George W. Thomas

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Bertrude Glad
6.(c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) Sept. 6 - 1869
8. AGE: Years 76 Months 2 Days 5 If less than one day
hrs. min.

9. Birthplace Croom Prince Georges Co
(Town, county, and state)
10. Usual occupation Minister of the Gospel
11. Industry or business Gospel
12. Name John Thomas
13. Birthplace near Croom Md
14. Maiden name Elizabeth Burch
15. Birthplace Unknown

16. Informant Mrs. George W. Thomas
Address Aberdeen 1750
17. Bural Date thereof Nov. 15, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Springfield
Location Baltimore Md
18. Funeral director Henry G. James Sons
Address Aberdeen Md
19. Nov. 15 19 45 Nellie A. Riley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 19 45 at 4:10 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 12 to Nov 14 19 45
and that I last saw him alive on Nov 11 19 45

Immediate cause of death Acute Valvular Heart Disease
DURATION
Due to Coronary Arteriosclerosis
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings at operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE H.K. Dulaney M.D. M. D. or other
Address Aberdeen Md Date signed Nov 15, 1945

RECEIVED

RECEIVED

RECEIVED

DEC 4 1945

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11138

Reg. Dist. No.

181

1. PLACE OF DEATH:

County.....Harford

City or town.....Rural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....1 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Harford

City or town.....Rural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)Street No.....Short Lane
(If rural, give LOCATION)

2.(a) If veteran, name war.....None

3. (a) FULL NAME

Mary M. Tildon

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

Caucas

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Frank Tildon Jr

8. (c) If alive, give age.....42 years

7. Birth date of

deceased (mo., day, yr.)

May 5-1900

8. AGE:

Years

Months

Days

If less than one day

45

6

hrs.

min.

9. Birthplace

Perryman Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

William B. Chase

13. Birthplace

Port Deposit Md

MOTHER

14. Maiden name

Mary Demmon

15. Birthplace

Perryman Md

16. Informant

Frank Tildon Jr

Address

Aberdeen Md. D.F.D.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Nov 12-1945
(month) (day) (year)

Cemetery or crematory

Union M.E.

Location

Near Aberdeen Md

18. Funeral director

Henry Tanning Sons

Address

Aberdeen Md

19.

Nov. 12

19

45 Nellie A. Riley

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Nov 8.....1945 at 6:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 1945 to Nov 8 1945

and that I last saw him alive on Nov 7 1945

Immediate cause of death

Respiratory
Failure

DURATION

Due to Metastatic Carcinoma

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings and operations: Cervical Carcinoma

Date of op. 1944

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

YB Jas tram ml
Aberdeen M. D. or other

Address..... Date signed 11-11-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 552 K

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County HartfordCity or town Joppa
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HartfordCity or town Joppa (Rural)
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Edith Marion Wagoner

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

S

6.(b) Name of husband or wife

L

7. Birth date of deceased (mo., day, yr.)

June 27 - 1925

6.(c) If alive, give age _____ years

8. AGE:

20

Years

Months

Days

If less than one day

_____ hrs. _____ min.

9. Birthplace

Rocks

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Mahlon C Wagoner

13. Birthplace

NC

MOTHER

14. Maiden name

Zollie M Wilson

15. Birthplace

NC

15. Informant

Mahlon C Wagoner

Address

Joppa MD17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov 25/45

(month) (day) (year)

Cemetery or crematory

Oak Grove

Location

Schuck's Corner

18. Funeral director

Dean's Inter

Address

Bel Air Md19. 11/23

(Date rec'd by registrar)

19. 45Prinville Toward

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 19 45, at 4:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-919. 45

to

11-2219. 45and that I last saw him alive on 11-22 19 45

Immediate cause of death

Transverse myelitis

DURATION

2 1/2 months

Due to

Sarcoma spine5 months

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations inoperable tumor of spine

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Fred O Hodous MD

M. D. or other

Address

Edgewood Md

Date signed

11-23-45

RECEIVED
NOV 27 1945
BUREAU V.K.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 793

CERTIFICATE OF DEATH

Reg. Dist. No. 11140 182

1. PLACE OF DEATH: *Harford*
 County.....
 City or town..... *Belt Air, Md*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... *60 years*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... *Md* County..... *Harford*
 City or town..... *Belt Air*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME *William White*

3.(b) Social Security Number

4. Sex *M* 5. Color or race *Col* 6.(a) Single, married, widowed, or divorced *W.*

6.(b) Name of husband or wife..... *Bertie W. White*

7. Birth date of deceased (mo., day, yr.) *Dec 25 - 1955* 6.(c) If alive, give age..... years

8. AGE: Years *89* Months Days If less than one day
 hrs. min.

9. Birthplace..... *Md*
 (Town, county, and state)

10. Usual occupation..... *labor*

11. Industry or business

12. Name..... *UNKNOWN*

13. Birthplace..... *UNKNOWN*

14. Maiden name..... *UNKNOWN*

15. Birthplace..... *UNKNOWN*

16. Informant..... *Col J & G Han*

Address..... *Belt Air, Md*

17. *Buried* Date thereof..... *Nov 17/45*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... *Hendon Hill*

Location..... *Near Belt Air, Md*

18. Funeral director..... *Dean Foster*

Address..... *Belt Air Md*

19. *11/17/* *46* *Priscilla Forward*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Nov 15* 19*45* at *4 P* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19....., to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Arteriosclerosis
C V Disease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Lorel P. Palmer M.D.
Deputy Medical Examiner
Harford County M.D. or other

23. SIGNATURE.....

Address..... *Belt Air Md* Date signed..... *11/17/45*

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NOV 20 1945
BUREAU V.E.